

health quality data, as specified by the Secretary, the unadjusted national prospective 60-day episode rate is equal to the rate for the previous calendar year increased by the applicable home health market basket index amount minus 2 percentage points. Any reduction of the percentage change will apply only to the calendar year involved and will not be taken into account in computing the prospective payment amount for a subsequent calendar year.

[65 FR 41212, July 3, 2000, as amended at 69 FR 62138, Oct. 22, 2004; 71 FR 65935, Nov. 9, 2006]

§ 484.230 Methodology used for the calculation of the low-utilization payment adjustment.

An episode with four or fewer visits is paid the national per-visit amount by discipline updated annually by the applicable market basket for each visit type. The national per-visit amount is determined by using cost data set forth in § 484.210(a) and adjusting by the appropriate wage index based on the site of service for the beneficiary. For 2008 and subsequent calendar years, an amount will be added to low-utilization payment adjustments for low-utilization episodes that occur as the beneficiary's only episode or initial episode in a sequence of adjacent episodes. For purposes of the home health PPS, a sequence of adjacent episodes for a beneficiary is a series of claims with no more than 60 days without home care between the end of one episode, which is the 60th day (except for episodes that have been PEP-adjusted), and the beginning of the next episode. This additional amount will be updated annually after 2008 by a factor equal to the applicable home health market basket percentage.

[65 FR 41212, July 3, 2000, as amended at 72 FR 69879, Aug. 29, 2007]

§ 484.235 Methodology used for the calculation of the partial episode payment adjustment.

(a) CMS makes a PEP adjustment to the original 60-day episode payment that is interrupted by an intervening event described in § 484.205(d).

(b) The original 60-day episode payment is adjusted to reflect the length

of time the beneficiary remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date.

(c) The partial episode payment is calculated by determining the actual days served by the original HHA as a proportion of 60 multiplied by the initial 60-day episode payment.

§ 484.240 Methodology used for the calculation of the outlier payment.

(a) CMS makes an outlier payment for an episode whose estimated cost exceeds a threshold amount for each case-mix group.

(b) The outlier threshold for each case-mix group is the episode payment amount for that group, the PEP adjustment amount for the episode plus a fixed dollar loss amount that is the same for all case-mix groups.

(c) The outlier payment is a proportion of the amount of estimated cost beyond the threshold.

(d) CMS imputes the cost for each episode by multiplying the national per-visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines.

(e) The fixed dollar loss amount and the loss sharing proportion are chosen so that the estimated total outlier payment is no more than 5 percent of total payment under home health PPS.

[65 FR 41212, July 3, 2000, as amended at 72 FR 69879, Aug. 29, 2007]

§ 484.245 Accelerated payments for home health agencies.

(a) *General rule.* Upon request, an accelerated payment may be made to an HHA that is receiving payment under the home health prospective payment system if the HHA is experiencing financial difficulties because there is a delay by the intermediary in making payment to the HHA.

(b) *Approval of payment.* An HHA's request for an accelerated payment must be approved by the intermediary and CMS.

(c) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(d) *Recovery of payment.* Recovery of the accelerated payment is made by

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recoupment as HHA bills are processed or by direct payment by the HHA.

§ 484.250 Patient assessment data.

(a) An HHA must submit to CMS the OASIS-C data described at § 484.55 (b)(1) and Home Health Care CAHPS data in order for CMS to administer the payment rate methodologies described in § 484.215, § 484.230, and § 484.235 of this subpart, and meet the quality reporting requirements of section 1895 (b)(3)(B)(v) of the Act.

(b) An HHA that has less than 60 eligible unique HHCAHPS patients annually must submit to CMS their total HHCAHPS patient count to CMS in order to be exempt from the HHCAHPS reporting requirements.

(c) An HHA must contract with an approved, independent HHCAHPS survey vendor to administer the HHCAHPS on its behalf.

(1) CMS approves an HHCAHPS survey vendor if such applicant has been in business for a minimum of three years and has conducted surveys of individuals and samples for at least 2 years. For HHCAHPS, a “survey of individuals” is defined as the collection of data from at least 600 individuals selected by statistical sampling methods and the data collected are used for statistical purposes. All applicants that meet these requirements will be approved by CMS.

(2) No organization, firm, or business that owns, operates, or provides staffing for a HHA is permitted to administer its own Home Health Care CAHPS (HHCAHPS) Survey or administer the survey on behalf of any other HHA in the capacity as an HHCAHPS survey vendor. Such organizations will not be approved by CMS as HHCAHPS survey vendors.

[75 FR 70465, Nov. 17, 2010]

§ 484.260 Limitation on review.

An HHA is not entitled to judicial or administrative review under sections 1869 or 1878 of the Act, or otherwise, with regard to the establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payments. An HHA is not entitled to the review regarding the establishment of the transition period, definition and

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application of the unit of payments, the computation of initial standard prospective payment amounts, the establishment of the adjustment for outliers, and the establishment of case-mix and area wage adjustment factors.

§ 484.265 Additional payment.

QIO photocopy and mailing costs. An additional payment is made to a home health agency in accordance with § 476.78 of this chapter for the costs of photocopying and mailing medical records requested by a QIO.

[68 FR 67960, Dec. 5, 2003]

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

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